# EXCERPTS OF

# SENATE BILL 1973, SENATE BILL 680, ASSEMBLY BILL 3050

# AND

# HEALTH AND SAFETY CODE SECTIONS 127280 and 128675-128810

# FOR EMERGENCY DEPARTMENT AND AMBULATORY SURGERY CLINICS

Office of Statewide Health Planning and Development
Patient Discharge Data Section
September 2003

# Senate Bill No. 1973

CHAPTER 735

An act to amend Sections 128695, 128700, 128725, 128735, 128755, 128760, 128782, and 128815 of, to amend, add, and repeal Section 127280 of, and to add Sections 128681, 128736, 128737, 128738, and 128812 to, the Health and Safety Code, relating to health data, and making an appropriation therefor.

[Approved by Governor September 21, 1998. Filed with Secretary of State September 22, 1998.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1973, Maddy. Health data.

(1) Existing law requires the Office of Statewide Health Planning and Development to charge a health facility a fee of not more than 0.035% of the gross operating cost of the health facility for the previous fiscal year, for deposit into the California Health Data and Planning Fund.

This bill would repeal those provisions on January 1, 2002, and enact similar provisions, on and after January 1, 2002, requiring the office to charge fees for health facilities and freestanding ambulatory surgery clinics for deposit into the fund.

(2) Existing law, the Health Data and Advisory Council Consolidation Act, until January 1, 1999, requires the office to be the single state agency designated to collect certain health facility or clinic data for use by all state agencies. Existing law establishes the California Health Policy and Data Advisory Commission to be composed of 11 members, with prescribed powers and duties. This bill would require the office to conduct, under contract with a consulting firm, a comprehensive review of the financial and utilization reports that hospitals are required to file, and other similar reports.

The bill would increase the membership of the commission to 13 members and impose term limits on the membership. The bill would require the office to present a work plan to the commission and would authorize the commission to monitor the office in achieving the goals of the work plan.

The bill would require the office, based upon review and recommendations of the commission and its appropriate committees, to allow and provide for additions or deletions to certain patient level data required to be reported.

The bill would require, after January 1, 2002, a hospital to file an Emergency Care Data Record for each patient encounter in a hospital emergency department, and a hospital and freestanding ambulatory surgery clinic to file an Ambulatory Surgery Data Record for each patient encounter during which at least one ambulatory surgery procedure is performed.

The bill would establish the time and manner in which those records are required to be filed with the office. The bill would revise the time and manner in which health facilities are required to file Hospital Discharge Abstract Data Records with the



office. The bill would revise the manner in which the office makes available copies of reports and publications.

The bill would require the office to provide prescribed financial and technical assistance to small and rural hospitals in meeting reporting requirements.

The bill would require the office to submit to the Legislature a plan to achieve the goal of data interchange among health facilities, health care service plans, insurers, providers, emergency medical services providers and local emergency medical services agencies, and other state agencies by June 30, 2001. The bill would require the office to engage an outside consulting organization to evaluate progress made by the office and make recommendations to the Legislature by June 30, 2003.

The bill would extend operation of the Health Data and Advisory Council Consolidation Act until June 30, 2004, and would extend repeal of the act until January 1, 2005. The bill would appropriate $1,240,500 from the California Health Planning and Data Fund to the office with $250,000 to be allocated for the purpose of conducting a comprehensive review of hospital reporting requirements and $990,500 to be allocated for systems development costs associated with the timeliness of the patient discharge data program and the collection of ambulatory surgery and emergency department records.

Appropriation: yes.

*The people of the State of California do enact as follows:*

SECTION 1. The Legislature finds and declares all of the following:

(a) Hospitals are a vital component of the state's health care system and, accordingly, are required by the state to file a variety of cost, utilization, and operational reports. These reports currently do not include patient care information involving emergency room and ambulatory surgery services.

(b) The information collected from hospitals serves a wide range of purposes, including management of state health care delivery and public health programs, efficient administration of hospital services, continuous improvement in the quality of care provided by hospitals, effective procurement of hospital services, and improvements in access to needed health care.

(c) It is in the interest of the hospital industry and all residents of the state that needed information about hospital services be collected from hospitals in the most efficient and effective manner possible.

(d) It is in the interest of the hospital and ambulatory surgical industries, as well as all the residents of the state, that needed information about ambulatory surgery services be collected for the same purposes and in the most efficient and effective manner possible.

(e) It is the intent of the Legislature that future efforts to collect information on ambulatory surgery services will include procedures performed in physician offices.

SEC. 2. Section 127280 of the Health and Safety Code is amended to read:

127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall be charged a fee of not more than 0.035 percent of the health facility's gross operating cost for the provision of health care services for its last fiscal year ending prior to the effective date of this section. Thereafter the office shall set for, charge to, and collect from all health facilities, except health facilities owned and operated by the state, a special fee, that shall be due on July 1, and delinquent on July 31 of each year beginning with the year 1977, of not more than 0.035 percent of the health facility's gross operating cost for provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year. Each year the office shall establish the fee to produce revenues equal to the appropriation to pay for the functions required to be performed pursuant to this chapter or Chapter 1 (commencing with Section 128675) of Part 5 by the office, the area and local health planning agencies, and the Advisory Health Council.

Health facilities that pay fees shall not be required to pay, directly or indirectly, the share of the costs of those health facilities for which fees are waived.

(b) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(c) Any amounts raised by the collection of the special fees provided for by subdivision (a) of this section that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office and the council in succeeding years when appropriated by the Legislature, for expenditure under the provisions of this chapter, and Chapter 1 (commencing with Section 128675) of Part 5 and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(d) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license
renewed unless the fees are paid. New, previously unlicensed health facilities shall be charged a pro rata fee to be established by the office during the first year of operation.

The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (a).

(e) This section shall remain in effect only until January 1, 2002, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2002, deletes or extends that date.

SEC. 3. Section 127280 is added to the Health and Safety Code, to read:

127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the



state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Every freestanding ambulatory surgery clinic as defined in Section 128700 shall each year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation to pay for the functions required to be performed pursuant to this chapter or Chapter 1 (commencing with Section 128675) of Part 5 by the office and the California Health Policy and Data Advisory Commission. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents ($0.50).

(2) (A) For the calendar year 2002 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2002 and shall report that number to the office by March 12, 2002. The estimate shall be as accurate as possible. The fee in the calendar year 2002 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents ($0.50) and shall be due on July 1 and delinquent on July 31, 2002.

(B) The office shall compare the actual number of records filed by each freestanding clinic for the calendar year 2002 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the office shall reduce the fee of the clinic for calendar year 2003 by the amount of the difference multiplied by fifty cents ($0.50). If the actual number reported exceeds the estimated number reported, the office shall increase the fee of the clinic for calendar year 2003 by the amount of the difference multiplied by fifty cents ($0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the office shall increase the fee of the clinic for calendar year 2003 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents ($0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar ($1).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office and the commission in succeeding years when appropriated by the Legislature for expenditure under
the provisions of this chapter and Chapter 1 (commencing with Section 128675) of Part 5, and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

# Senate Bill No. 680

CHAPTER 898

An act to amend Sections 128735, 128736, 128737, 128740, 128745, 128750, 128755, and 128765 of, to add Sections 128747 and 128748 to, and to repeal Section 128815 of, the Health and Safety Code, relating to health data.

[Approved by Governor October 14, 2001. Filed with Secretary of State October 14, 2001.]

LEGISLATIVE COUNSEL'S DIGEST

SB 680, Figueroa. Health facility data.

Existing law, the Health Data and Advisory Council Consolidation Act, operative until June 30, 2004, requires every organization that operates, conducts, or maintains a health facility to make and file with the Office of Statewide Health Planning and Development, specified reports containing various financial and patient data.

This bill would additionally impose the above requirements on every organization that owns a health facility.

This bill would revise the type of data required to be filed with the office.

Existing law also requires that the office publish certain patient outcome reports for specified periods.

This bill would revise the data that the office shall publish and would revise the periods to which the reports shall apply.

Existing law requires the office to maintain a file of all reports filed under the Health Data and Advisory Council Consolidation Act.

This bill would require the office also to post all reports on its Web site, and would specify that the reports include a discussion of findings, conclusions, and trends concerning the overall quality of medical outcomes for procedures and conditions studied by the reports.

The bill would delete the provision limiting the duration of the operation of the Health Data and Advisory Council Consolidation Act.

*The people of the State of California do enact as follows:*

SECTION 1. The Legislature finds and declares the following:

(a) Public disclosure of the outcomes of surgical and other hospital procedures facilitates public and market accountability, reduces mortality rates, and generally



promotes improvement in the quality of medical outcomes. Providing this information to purchasers, consumers, hospitals, and providers will enable all market players to act based on more complete information on quality of care.

(b) Improved collection and dissemination of medical outcomes data by hospital and, for surgical procedures or conditions, by surgeon, will provide hospitals and providers information needed to conduct quality improvement efforts, will improve decision making by purchasers of health care and consumers, will better inform decisions about resource allocation and regulation, and will result in cost savings.

(c) It is, therefore, the intent of the Legislature to facilitate the continuing provision of quality health services throughout the state by providing current, accurate data and information to purchasers, health care service plans, health and disability insurers, consumers, hospitals, and physicians on quality of health care services.

# Assembly Bill No. 3050

CHAPTER 351

An act to amend Sections 127280, 128736, 128737, 129075, 129085, 129174, 129680, 129725, 129785, and 129905 of, and to repeal Section 129845 of, the Health and Safety Code, relating to health facilities.

[Approved by Governor August 31, 2002. Filed with Secretary of State September 3, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

AB 3050, Committee on Health. Health facilities.

(1) Existing law, commencing January 1, 2002, requires each hospital and freestanding ambulatory surgery clinic to file, with the Office of Statewide Health Planning and Development, specified reports containing various patient and health data information. This bill would extend the operative date of these provisions to January 1, 2004.

(2) Existing law, commencing January 1, 2002, requires freestanding ambulatory surgery clinics to be charged a fee established by the office consistent with specified statutory requirements.

This bill would impose this requirement commencing in calendar year 2004.

(3) The existing California Health Facility Construction Loan Insurance Law provides, without cost to the state, an insurance program for health facility construction, improvement, and expansion loans in order to stimulate the flow of private capital into health facilities construction, improvement, and expansion, and in order to meet the need for new, expanded, and modernized public and nonprofit health facilities. Existing law imposes various functions and duties on the Office of Statewide Health Planning and Development with respect to the administration of this program. Existing law authorizes the office to take certain steps in the event of a borrower's default.

This bill would also authorize the office to require the lender or borrower's bond trustee to accelerate the borrower's debt and maturity dates of the bonds, if any. It would require the office to pay the lender or borrower's bond trustee the full amount of the remaining principal of the loan and other prescribed amounts.

(4) The bill would eliminate an obsolete provision of law and would also make various technical, nonsubstantive, and conforming changes to all of the above provisions.

# HEALTH AND SAFETY CODE
# SECTION 127280 and 128675-128810



127280. (a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Commencing in calendar year 2004, every freestanding ambulatory surgery clinic as defined in Section 128700, shall each year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation made in the annual Budget Act or another statute to pay for the functions required to be performed by the office and the California Health Policy and Data Advisory Commission pursuant to this chapter, Article 2 (commencing with Section 127340) of Chapter 2, or Chapter 1 (commencing with Section 128675) of Part 5, and to pay for any other health-related programs administered by the office. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents ($0.50).

(2) (A) For the calendar year 2004 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2004 and shall report that number to the office by March 12, 2004. The estimate shall be as accurate as possible. The fee in the calendar year 2004 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents ($0.50) and shall be due on July 1 and delinquent on July 31, 2004.

(B) The office shall compare the actual number of records filed by each freestanding clinic for the calendar year 2004 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the office shall reduce the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50). If the actual number reported exceeds the estimated number reported, the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents ($0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents ($0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar ($1).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office and the commission in succeeding years when appropriated by the Legislature in the annual Budget Act or another statute, for expenditure under the provisions of this chapter, Article 2 (commencing with Section 127340) of Chapter 2, and Chapter 1 (commencing with Section 128675) of Part 5, or for any other health-related programs administered by the office, and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

128675. This chapter shall be known as the Health Data and Advisory Council Consolidation Act.

128680. The Legislature hereby finds and declares that:

(a) Significant changes have taken place in recent years in the health care marketplace and in the manner of reimbursement to health facilities by government and private third-party payers for the services they provide.

(b) These changes have permitted the state to reevaluate the need for, and the manner of data collection from health facilities by the various state agencies and commissions.

(c) It is the intent of the Legislature that as a result of this reevaluation that the data collection function be consolidated in a single state agency. It is the further intent of the Legislature that the single state agency only collect that data from health facilities that are essential. The data should be collected, to the extent practical on consolidated, multipurpose report forms for use by all state agencies.

(d) It is the further intent of the Legislature to eliminate the California Health Facilities Commission and the State Advisory Health Council, and to create a single advisory commission to assume consolidated data collection and planning functions.

(e) It is the Legislature's further intent that the review of the data that the state collects be an ongoing function. The office, with the advice of the advisory commission, shall annually review this data for need and shall revise, add, or delete items as necessary. The commission and the office shall consult with affected state agencies and the affected industry when adding or eliminating data items. However, the office shall neither add nor delete data items to the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or judicial decision.

(f) The Legislature recognizes that the authority for the California Health Facilities Commission is scheduled to expire January 1, 1986. It is the intent of the Legislature, by the enactment of this chapter, to continue the uniform system of accounting and reporting established by the commission and required for use by health facilities. It is also the intent of the Legislature to continue an appropriate, cost-disclosure program.

128681. The office shall conduct, under contract with a qualified consulting firm, a comprehensive review of the financial and utilization reports that hospitals are required to file with the office and similar reports required by other departments of state government, as appropriate. The contracting consulting firm shall have a strong commitment to public health and health care issues, and shall demonstrate fiscal management and analytical expertise. The purpose of the review is to identify opportunities to eliminate the collection of data that no longer serve any significant purpose, to reduce the redundant reporting of similar data to different departments, and to consolidate reports wherever practical. The contracting consulting firm shall evaluate specific reporting requirements, exceptions to and exemptions from the requirements, and areas of duplication or overlap within the requirements. The contracting consulting firm shall consult with a broad range of data users, including, but not limited to, consumers, payers, purchasers, providers, employers, employees, and the organizations that represent the data users. It is expected that the review will result in greater efficiency in collecting and disseminating needed hospital information to the public and will reduce hospital costs and administrative burdens associated with reporting the information.

128685. Intermediate care facilities/developmentally disabled-habilitative, as defined in subdivision (e) of Section 1250, are not subject to this chapter.

128690. Intermediate care facilities/developmentally disabled--nursing, as defined in subdivision (h) of Section 1250, are not subject to this chapter.

128695. There is hereby created the California Health Policy and Data Advisory Commission to be composed of 13 members. The Governor shall appoint nine



members, one of whom shall be a hospital chief executive officer, one of whom shall be a chief executive officer of a hospital serving a disproportionate share of low-income patients, one of whom shall be a long-term care facility chief executive officer, one of whom shall be a freestanding ambulatory surgery clinic chief executive officer, one of whom shall be a representative of the health insurance industry involved in establishing premiums or underwriting, one of whom shall be a representative of a group prepayment health care service plan, one of whom shall be a representative of a business coalition concerned with health, and two of whom shall be general members. The Speaker of the Assembly shall appoint two members, one of whom shall be a physician and surgeon and one of whom shall be a general member. The Senate Rules Committee shall appoint two members, one of whom shall be a representative of a labor coalition concerned with health, and one of whom shall be a general member. The Governor shall designate a member to serve as chairperson for a two-year term. No member may serve more than two, two-year terms as chairperson. All appointments shall be for four-year terms. No individual shall serve more than two, four-year terms.

128700. As used in this chapter, the following terms mean:

(a) "Ambulatory surgery procedures" mean those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic.

(b) "Commission" means the California Health Policy and Data Advisory Commission.

(c) "Emergency department" means, in a hospital licensed to provide emergency medical services, the location in which those services are provided.

(d) "Encounter" means a face-to-face contact between a patient and the provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient.

(e) "Freestanding ambulatory surgery clinic" means a surgical clinic that is licensed by the state under paragraph (1) of subdivision (b) of Section 1204.

(f) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(g) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.

(h) "Office" means the Office of Statewide Health Planning and Development.

(i) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures that have been adjusted for demographic and clinical factors.

128705. On and after January 1, 1986, any reference in this code to the Advisory Health Council shall be deemed a reference to the California Health Policy and Data Advisory Commission.

128710. The California Health Policy and Data Advisory Commission shall meet at least once every two months, or more often if necessary to fulfill its duties.

128715. The members of the commission shall receive per diem of one hundred dollars ($100) for each day actually spent in the discharge of official duties and shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the commission.

128720. The commission may appoint an executive secretary subject to approval by the Secretary of Health and Welfare. The office shall provide other staff to the commission as the office and the commission deem necessary.

128725. The functions and duties of the commission shall include the following:

(a) Advise the office on the implementation of the new, consolidated data system.

(b) Advise the office regarding the ongoing need to collect and report health facility data and other provider data.

(c) Annually develop a report to the director of the office regarding changes that should be made to existing data collection systems and forms. Copies of the report shall be provided to the Senate Health and Human Services Committee and to the Assembly Health Committee.

(d) Advise the office regarding changes to the uniform accounting and reporting systems for health facilities.

(e) Conduct public meetings for the purposes of obtaining input

from health facilities, other providers, data users, and the general public regarding this chapter and Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(f) Advise the Secretary of Health and Welfare on the formulation of general policies which shall advance the purposes of this part.

(g) Advise the office on the adoption, amendment, or repeal of regulations it proposes prior to their submittal to the Office of Administrative Law.

(h) Advise the office on the format of individual health facility or other provider data reports and on any technical and procedural issues necessary to implement this part.

(i) Advise the office on the formulation of general policies which shall advance the purposes of Chapter 1 (commencing with Section 127125) of Part 2 of Division 107.

(j) Recommend, in consultation with a 12-member technical advisory committee appointed by the chairperson of the commission, to the office the data elements necessary for the production of outcome reports required by Section 128745.

(k) (1) The technical advisory committee appointed pursuant to subdivision (j) shall be composed of two members who shall be hospital representatives appointed from a list of at least six persons nominated by the California Association of Hospitals and Health Systems, two members who shall be physicians and surgeons appointed from a list of at least six persons nominated by the California Medical



Association, two members who shall be registered nurses appointed from a list of at least six persons nominated by the California Nurses Association, one medical record practitioner who shall be appointed from a list of at least six persons nominated by the California Health Information Association, one member who shall be a representative of a hospital authorized to report as a group pursuant to subdivision (d) of Section 128760, two members who shall be representative of California research organizations experienced in effectiveness review of medical procedures or surgical procedures, or both procedures, one member representing the Health Access Foundation, and one member representing the Consumers Union. Members of the technical advisory committee shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the technical advisory committee.

(2) The commission shall submit its recommendation to the office regarding the first of the reports required pursuant to subdivision (a) of Section 128745 no later than January 1, 1993. The technical advisory committee shall submit its initial recommendations to the commission pursuant to subdivision (d) of Section 128750 no later than January 1, 1994. The commission, with the advice of the technical advisory committee, may periodically make additional recommendations under Sections 128745 and 128750 to the office, as appropriate.

(l) (1) Assess the value and usefulness of the reports required by Sections 127285, 128735, and 128740. On or before December 1, 1997, the commission shall submit recommendations to the office to accomplish all of the following:

(A) Eliminate redundant reporting.

(B) Eliminate collection of unnecessary data.

(C) Augment data bases as deemed valuable to enhance the quality and usefulness of data.

(D) Standardize data elements and definitions with other health data collection programs at both the state and national levels.

(E) Enable linkage with, and utilization of, existing data sets.

(F) Improve the methodology and data bases used for quality assessment analyses, including, but not limited to, risk-adjusted outcome reports.

(G) Improve the timeliness of reporting and public disclosure.

(2) The commission shall establish a committee to implement the evaluation process. The committee shall include representatives from the health care industry, providers, consumers, payers, purchasers, and government entities, including the Department of Managed Health Care, the departments that comprise the Health and Welfare Agency, and others deemed by the commission to be appropriate to the evaluation of the data bases. The committee may establish subcommittees including technical experts.

(3) In order to ensure the timely implementation of the provisions of the legislation enacted in the 1997-98 Regular Session that amended this part, the office shall present an implementation work plan to the commission. The work plan shall clearly define goals and significant steps within specified timeframes that must be completed in order to accomplish the purposes of that legislation. The office shall

make periodic progress reports based on the work plan to the commission. The commission may advise the Secretary of Health and Welfare of any significant delays in following the work plan. If the commission determines that the office is not making significant progress toward achieving the goals outlined in the work plan, the commission shall notify the office and the secretary of that determination. The commission may request the office to submit a plan of correction outlining specific remedial actions and timeframes for compliance. Within 90 days of notification, the office shall submit a plan of correction to the commission.

(m) (1) As the office and the commission deem necessary, the commission may establish committees and appoint persons who are not members of the commission to these committees as are necessary to carry out the purposes of the commission. Representatives of area health planning agencies shall be invited, as appropriate, to serve on committees established by the office and the commission relative to the duties and responsibilities of area health planning agencies. Members of the standing committees shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of these committees.

(2) Whenever the office or the commission does not accept the advice of the other body on proposed regulations or on major policy issues, the office or the commission shall provide a written response on its action to the other body within 30 days, if so requested.

(3) The commission or the office director may appeal to the Secretary of Health and Welfare over disagreements on policy, procedural, or technical issues.

128730. (a) Effective January 1, 1986, the office shall be the single state agency designated to collect the following health facility or clinic data for use by all state agencies:

(1) That data required by the office pursuant to Section 127285.

(2) That data required in the Medi-Cal cost reports pursuant to Section 14170 of the Welfare and Institutions Code.

(3) Those data items formerly required by the California Health Facilities Commission that are listed in Sections 128735 and 128740. Information collected pursuant to subdivision (g) of Section 128735 shall be made available to the State Department of Health Services. The department shall ensure that the patient's rights to confidentiality shall not be violated in any manner. The department shall comply with all applicable policies and requirements involving review and oversight by the State Committee for the Protection of Human Subjects.

(b) The office shall consolidate any and all of the reports listed under this section or Sections 128735 and 128740, to the extent feasible, to minimize the reporting burdens on hospitals. Provided, however, that the office shall neither add nor delete data items from the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or regulation or judicial decision.



128735. Every organization that operates, conducts, owns, or maintains a health facility, and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on forms specified by the office that shall be in accord where applicable with the systems of accounting and uniform reporting required by this part, except the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center except that hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760 are not required to report revenue by revenue center.

(d) A statement of cash-flows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting organization, except those hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760.

(f) Data reporting requirements established by the office shall be consistent with national standards, as applicable.

(g) A Hospital Discharge Abstract Data Record that includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) ZIP Code.

(5) Principal language spoken.

(6) Patient social security number, if it is contained in the patient's medical record.

(7) Prehospital care and resuscitation, if any, including all of the following:

(A) "Do not resuscitate" (DNR) order at admission.

(B) "Do not resuscitate" (DNR) order after admission.

(8) Admission date.

(9) Source of admission.

(10) Type of admission.

(11) Discharge date.

(12) Principal diagnosis and whether the condition was present at admission.

(13) Other diagnoses and whether the conditions were present at admission.

(14) External cause of injury.

(15) Principal procedure and date.

(16) Other procedures and dates.

(17) Total charges.

(18) Disposition of patient.
(19) Expected source of payment.
(20) Elements added pursuant to Section 128738.

(h) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (g).

(j) A hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

128736. (a) Each hospital shall file an Emergency Care Data Record for each patient encounter in a hospital emergency department. The Emergency Care Data Record shall include all of the following:

(1) Date of birth.
(2) Sex.
(3) Race.
(4) Ethnicity.
(5) Principal language spoken.
(6) ZIP Code.
(7) Patient social security number, if it is contained in the patient's medical record.
(8) Service date.
(9) Principal diagnosis.
(10) Other diagnoses.
(11) Principal external cause of injury.
(12) Other external cause of injury.
(13) Principal procedure.
(14) Other procedures.
(15) Disposition of patient.
(16) Expected source of payment.
(17) Elements added pursuant to Section 128738.

(b) It is the expressed intent of the Legislature that the patient' s rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).



(c) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (a).

(d) Data reporting requirements established by the office shall be consistent with national standards as applicable.

(e) This section shall become operative on January 1, 2004.

128737. (a) Each hospital and freestanding ambulatory surgery clinic shall file an Ambulatory Surgery Data Record for each patient encounter during which at least one ambulatory surgery procedure is performed. The Ambulatory Surgery Data Record shall include all of the following:

(1) Date of birth.
(2) Sex.
(3) Race.
(4) Ethnicity.
(5) Principal language spoken.
(6) ZIP Code.
(7) Patient social security number, if it is contained in the patient's medical record.
(8) Service date.
(9) Principal diagnosis.
(10) Other diagnoses.
(11) Principal procedure.
(12) Other procedures.
(13) Principal external cause of injury, if known.
(14) Other external cause of injury, if known.
(15) Disposition of patient.
(16) Expected source of payment.
(17) Elements added pursuant to Section 128738.

(b) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (a).

(d) Data reporting requirements established by the office shall be consistent with national standards as applicable.

(e) This section shall become operative on January 1, 2004.

128738. (a) The office, based upon review and recommendations of the commission and its appropriate committees, shall allow and provide for, in accordance with appropriate regulations, additions or deletions to the patient level data elements listed in subdivision (g) of Section 128735, Section 128736, and Section 128737, to meet the purposes of this chapter.

(b) Prior to any additions or deletions, all of the following shall be considered:

(1) Utilization of sampling to the maximum extent possible.

(2) Feasibility of collecting data elements.

(3) Costs and benefits of collection and submission of data.

(4) Exchange of data elements as opposed to addition of data elements.

(c) The office shall add no more than a net of 15 elements to each data set over any five-year period. Elements contained in the uniform claims transaction set or uniform billing form required by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg) shall be exempt from the 15-element limit.

(d) The commission and the office, in order to minimize costs and administrative burdens, shall consider the total number of data elements required from hospitals and freestanding ambulatory surgery clinics, and optimize the use of common data elements.

128740. (a) Commencing with the first calendar quarter of 1992, the following summary financial and utilization data shall be reported to the office by each hospital within 45 days of the end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.

(7) Total operating expenses.

(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(11) Total capital expenditures.



(12) Total net fixed assets.

(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(15) Other operating revenue.

(16) Nonoperating revenue net of nonoperating expenses.

(b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (7), (8), (9), (10), (14), (15), and (16) of subdivision (a) on a group basis, as described in subdivision (d) of Section 128760.

(c) The office shall make available at cost, to any person, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(d) The office, with the advice of the commission, shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

This section shall become operative January 1, 1992.

128745. (a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

| Publication Date | Period Covered | Procedures and Conditions Covered |
|---|---|---|
| July 1993 | 1988-90 | 3 |
| July 1994 | 1989-91 | 6 |
| July 1995 | 1990-92 | 9 |

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions required to be reported under this chapter shall be divided among medical, surgical and obstetric conditions or procedures and shall be selected by the office, based on the recommendations of the commission and the advice of the technical advisory committee set forth in subdivision (j) of Section 128725. The office shall publish the risk-adjusted outcome reports for surgical procedures by individual hospital and individual surgeon unless the office in consultation with the technical advisory committee and medical specialists in the

relevant area of practice determines that it is not appropriate to report by individual surgeon. The office, in consultation with the technical advisory committee and medical specialists in the relevant area of practice, may decide to report nonsurgical procedures and conditions by individual physician when it is appropriate. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment. The risk adjustment report shall ensure that public hospitals and other hospitals serving primarily low-income patients are not unfairly discriminated against.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases and the seriousness of the health consequences of the procedure or condition.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) (1) In addition to any other established and pending reports, on or before July 1, 2002, the office shall publish a risk-adjusted outcome report for coronary artery bypass graft surgery by hospital for all hospitals opting to participate in the report. This report shall be updated on or before July 1, 2003.

(2) In addition to any other established and pending reports, commencing July 1, 2004, and every year thereafter, the office shall publish risk-adjusted outcome reports for coronary artery bypass graft surgery for all coronary artery bypass graft surgeries performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and cardiac surgeon. Upon the recommendation of the technical advisory committee based onstatistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

(3) Unless otherwise recommended by the clinical panel established by Section 128748, the office shall collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Mortality Reporting Program. Upon recommendation of the clinical panel, the office may add any clinical data elements included in the Society of Thoracic Surgeons' data base. Prior to any additions from the Society of Thoracic Surgeons' data base, the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Exchange of data elements as opposed to addition of data elements.

(4) Upon recommendation of the clinical panel, the office may add, delete or revise clinical data elements, but shall add no more than a net of six elements not included in the Society of Thoracic Surgeons' data base, to the data set over any five-year period. Prior to any additions or deletions, all of the following factors
shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Feasibility of collecting data elements.

(C) Costs and benefits of collection and submission of data.

(D) Exchange of data elements as opposed to addition of data elements.



(5) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the coronary artery bypass graft report.

(d) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings for each hospital:

(1) "Much higher than average outcomes," for hospitals with risk-adjusted outcomes much higher than the norm.

(2) "Higher than average outcomes," for hospitals with risk-adjusted outcomes higher than the norm.

(3) "Average outcomes," for hospitals with average risk-adjusted outcomes.

(4) "Lower than average outcomes," for hospitals withrisk-adjusted outcomes lower than the norm.

(5) "Much lower than average outcomes," for hospitals with risk-adjusted outcomes much lower than the norm.

(e) For coronary artery bypass graft surgery reports and any other outcome reports for which auditing is appropriate, the office shall conduct periodic auditing of data at hospitals.

(f) The office shall publish in the annual reports required under this section the risk-adjusted mortality rate for each hospital and for those reports that include physician reporting, for each physician.

(g) The office shall either include in the annual reports required under this section, or make separately available at cost to any person requesting it, risk-adjustedoutcomes data assessing the statistical significance of hospital or physician data at each of the following three levels: 99 percent confidence level (0.01 p-value), 95 percent confidence level (0.05 p-value), and 90 percent confidence level (.10 p-value). The office shall include any other analysis or comparisons of the data in the annual reports required under this section that the office deems appropriate to further the purposes of this chapter.

128747. Commencing July 1, 2002, and biennially thereafter, the office shall evaluate the impact of the office's published risk-adjusted outcome reports required by Sections 128745 and 128746 on mortality rates in California and on any other measure of quality the office deems appropriate. The office shall also coordinate with other state agencies in promoting prevention and educational initiatives on those reported procedures and conditions.

128748. (a) This section shall apply to any risk-adjusted outcome report that includes reporting of data by an individual physician.

(b) (1) The office shall obtain data necessary to complete a risk-adjusted outcome report from hospitals. If necessary data for an outcome report is available only from the office of a physician and not the hospital where the patient received treatment, then the hospital shall make a reasonable effort to obtain the data from the physician's office and provide the data to the office. In the event that the office finds

any errors, omissions, discrepancies, or other problems with submitted data, the office shall contact either the hospital or physician's office that maintains the data to resolve the problems.

(2) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model. Except for data collected for purposes of testing or validating a risk-adjusted model, the office shall not collect data for an outcome report nor issue an outcome report until the clinical panel established pursuant to this section has approved the risk-adjusted model.

(c) For each risk-adjusted outcome report on a medical, surgical, or obstetric condition or procedure that includes reporting of data by an individual physician, the office director shall appoint a clinical panel, which shall have nine members. Three members shall be appointed from a list of three or more names submitted by the physician specialty society that most represents physicians performing the medical, surgical, and obstetric procedure for which data is collected. Three members shall be appointed from a list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees from the lists submitted by the physician specialty society and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements for physicians or hospitals. The panel may include physicians from another state. The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

(d) For the clinical panel authorized by subdivision (c) for coronary artery bypass graft surgery, three members shall be appointed from a list of three or more names submitted by the California Chapter of the American College of Cardiology. Three members shall be appointed from list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees from the lists submitted by the California Chapter of the American College of Cardiology, and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements for physicians and surgeons or hospitals. The panel may include physicians from another state. The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

(e) Any report that includes reporting by an individual physician shall include, at a minimum, the risk-adjusted outcome data for each physician. The office may also include in the report, after consultation with the clinical panel, any explanatory material, comparisons, groupings, and other information to facilitate consumer comprehension of the data.

(f) Members of a clinical panel shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the clinical panel.



128750. (a) Prior to the public release of the annual outcome reports, the office shall furnish a preliminary report to each hospital that is included in the report. The office shall allow the hospital and chief of staff 60 days to review the outcome scores and compare the scores to other California hospitals. A hospital or its chief of staff that believes that the risk-adjusted outcomes do not accurately reflect the quality of care provided by the hospital may submit a statement to the office, within the 60 days, explaining why the outcomes do not accurately reflect the quality of care provided by the hospital. The statement shall be included in an appendix to the public report, and a notation that the hospital or its chief of staff has submitted a statement shall be displayed wherever the report presents outcome scores for the hospital.

(b) (1) Prior to the public release of any outcome report that includes data by a physician, the office shall furnish a preliminary report to each physician that is included in the report. The office shall allow the physician 30 days from the date the office sends the report to the physician to review the outcome scores and compare the scores to other California physicians. A physician who believes that the risk-adjusted outcome does not accurately reflect the quality of care provided by the physician may submit a statement to the office within the 30 days, explaining why the outcomes do not accurately reflect the quality of care provided by the physician.

(2) The office shall promptly review the physician's statement and shall respond to the physician with one of the following conclusions:

(A) The physician's statement reveals a flaw in the accuracy of the reported data relating to the physician that materially diminishes the validity of the report. If this finding is made, the data for that physician shall not be included in the report until the flaw in the physician's data is corrected.

(B) The physician's statement reveals a flaw in the risk-adjustment model that materially diminishes the value of the report for all physicians. If this finding is made, the report using that risk-adjustment model shall not be issued until the flaw is corrected.

(C) The physician's statement does not reveal a flaw in either the accuracy of the reported data relating to the physician or the risk-adjustment model in which case the report shall be used, unless the physician chooses to use the procedure set forth in paragraph (3).

(3) If a physician is not satisfied with the conclusion reached by the office, the physician shall notify the office of that fact. Upon receipt of the notice, the office shall forward the physician's statement to the appropriate clinical panel appointed pursuant to Section 128748. The office shall forward the physician's statement with any information identifying the physician or the physician's hospital redacted, or shall adopt other means to ensure the physician's identity is not revealed to the panel. The clinical panel shall promptly review the physician statement and the conclusion of the office and shall respond by either upholding the conclusion or reaching one of the other conclusions set forth in this subdivision. The panel decision shall be the final determination regarding the physician's statement. The process set forth in this subdivision shall be completed within 60 days from the date the office sends the report to each physician included in the report. If a decision by either the office or

the clinical panel cannot be reached within the 60-day period, then the outcome report may be issued but shall not include data for the physician submitting the statement.

(c) The office shall, in addition to public reports, provide hospitals and the chiefs of staff of the medical staffs with a report containing additional detailed information derived from data summarized in the public outcome reports as an aid to internal quality assurance.

(d) If, pursuant to the recommendations of the office, based on the advice of the commission, in response to the recommendations of the technical advisory committee made pursuant to subdivision (d) of this section, the Legislature subsequently amends Section 128735 to authorize the collection of additional discharge data elements, then the outcome reports for conditions and procedures for which sufficient data is not available from the current abstract record will be produced following the collection and analysis of the additional data elements.

(e) The recommendations of the technical advisory committee for the addition of data elements to the discharge abstract should take into consideration the technical feasibility of developing reliable risk-adjustment factors for additional procedures and conditions as determined by the technical advisory committee with the advice of the research community, physicians and surgeons, hospitals, consumer or patient advocacy groups, and medical records personnel.

(f) The technical advisory committee at a minimum shall identify a limited set of core clinical data elements to be collected for all of the added procedures and conditions and unique clinical variables necessary for risk adjustment of specific conditions and procedures selected for the outcomes report program. In addition, the committee should give careful consideration to the costs associated with the additional data collection and the value of the specific information to be collected.

(g) The technical advisory committee shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

128755. (a) (1) Hospitals shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the hospital's fiscal year except as provided in paragraph (2).

(2) If a licensee relinquishes the facility license or puts the facility license in suspense, the last day of active licensure shall be deemed a fiscal year end.

(3) The office shall make the reports filed pursuant to this subdivision available no later than three months after they were filed.

(b) (1) Skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, and congregate living facilities, including nursing facilities certified by the state department to participate in the Medi-Cal program, shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the facility's fiscal year, except as provided in paragraph (2).



(2) (A) If a licensee relinquishes the facility license or puts the facility licensure in suspense, the last day of active licensure shall be deemed a fiscal year end.

(B) If a fiscal year end is created because the facility license is relinquished or put in suspense, the facility shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 within two months after the last day of active licensure.

(3) The office shall make the reports filed pursuant to paragraph (1) available not later than three months after they are filed.

(4) (A) Effective for fiscal years ending on or after December 31, 1991, the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 shall be filed with the office by electronic media, as determined by the office.

(B) Congregate living health facilities are exempt from the electronic media reporting requirements of subparagraph (A).

(c) A hospital shall file the reports required by subdivision (g) of Section 128735 as follows:

(1) For patient discharges on or after January 1, 1999, through December 31, 1999, the reports shall be filed semiannually by each hospital or its designee not later than six months after the end of each semiannual period, and shall be available from the office no later than six months after the date that the report was filed.

(2) For patient discharges on or after January 1, 2000, through December 31, 2000, the reports shall be filed semiannually by each hospital or its designee not later than three months after the end of each semiannual period. The reports shall be filed by electronic tape, diskette, or similar medium as approved by the office. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the date that the report is approved.

(3) For patient discharges on or after January 1, 2001, the reports shall be filed by each hospital or its designee for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the date that the report is approved.

(d) The reports required by subdivision (a) of Section 128736 shall be filed by each hospital for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A

report shall be available from the office no later than 15 days after the report is approved.

(e) The reports required by subdivision (a) of Section 128737 shall be filed by each hospital or freestanding ambulatory surgery clinic for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information.

The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the report is approved.

(f) Facilities shall not be required to maintain a full-time electronic connection to the office for the purposes of online transmission of reports as specified in subdivisions (c), (d), and (e). The office may grant exemptions to the online transmission of data requirements for limited periods to facilities. An exemption may be granted only to a facility that submits a written request and documents or demonstrates a specific need for an exemption. Exemptions shall be granted for no more than one year at a time, and for no more than a total of five consecutive years.

(g) The reports referred to in paragraph (2) of subdivision (a) of Section 128730 shall be filed with the office on the dates required by applicable law and shall be available from the office no later than six months after the date that the report was filed.

(h) The office shall post on its Web site and make available to any person a copy of any report referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, Section 128740, and, in addition, shall make available in electronic formats reports referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, Section 128740, and subdivisions (a) and (c) of Section 128745, unless the office determines that an individual patient's rights of confidentiality would be violated. The office shall make the reports available at cost.

128760. (a) On and after January 1, 1986, those systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities but shall be maintained by the office with the advice of the Health Policy and Data Advisory Commission.

(b) The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this chapter if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.



(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) Modifications to discharge data reporting requirements. The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) Modifications to emergency care data reporting requirements. The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to emergency care data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) Modifications to ambulatory surgery data reporting requirements. The office, with the advice of the commission, shall allow and provide, in accordance with appropriate regulations, for modifications to ambulatory surgery data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not be construed to permit the office to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

(f) Reporting provisions for health facilities. The office, with the advice of the commission, shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner that is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of a coordinated group of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.

(g) Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 128735. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.

(h) The office, with the advice of the commission, shall adopt comparable modifications to the financial reporting requirements of this chapter for county hospital systems consistent with the purposes of this chapter.

128765. (a) The office, with the advice of the commission, shall maintain a file of all the reports filed under this chapter at its Sacramento office. The office shall also post all reports on its Web site. Subject to any rules the office, with the advice of the commission, may prescribe, these reports shall be produced and made available for inspection upon the demand of any person, with the exception of hospital discharge abstract data that shall be available for public inspection unless the office determines that an individual patient's rights of confidentiality would be violated.

(b) The reports filed under this chapter shall include an executive summary, written in plain English to the maximum extent practicable, that shall include, but not be limited to, a discussion of findings, conclusions, and trends concerning the overall quality of medical outcomes, including a comparison to reports from prior years, for the procedure or condition studied by the report. The office shall disseminate the reports as widely as practical to interested parties, including, but not limited to, hospitals, providers, the media, purchasers of health care, consumer or patient advocacy groups, and individual consumers.

(c) Copies certified by the office as being true and correct, copies of reports properly filed with the office pursuant to this chapter, together with summaries, compilations, or supplementary reports prepared by the office, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local governmental agency, board, or commission that participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal health care program. Each of these state, county, or local governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to the provisions of this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(d) The office, with the advice of the commission, shall compile and publish summaries of the data for the purpose of public disclosure. The commission shall approve the policies and procedures relative to the manner of data disclosure to the public. The office, with the advice of the commission, may initiate and conduct studies as it determines will advance the purposes of this chapter.

(e) In order to assure that accurate and timely data are available to the public in useful formats, the office shall establish a public liaison function. The public liaison shall provide technical assistance to the general public on the uses and applications of individual and aggregate health facility data and shall provide the director and the commission with an annual report on changes that can be made to improve the public's access to data.

(f) In addition to its public liaison function, the office shall continue the publication of aggregate industry and individual health facility cost and operational data published by the California Health Facilities Commission as described in subdivision



(b) of Section 441.95, as that section existed on December 31, 1985. This publication shall be submitted to the Legislature not later than March 1 of each year commencing with calendar year 1986 and in addition shall be offered for sale as a public document.

128770. (a) Any health facility that does not file any report as required by this chapter with the office is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the office, with the advice of the commission.

(b) Any health facility that does not use an approved system of accounting pursuant to the provisions of this chapter for purposes of submitting financial and statistical reports as required by this chapter shall be liable for a civil penalty of not more than five thousand dollars ($5,000).

(c) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the office. Assessment of a civil penalty may, at the request of any health facility, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(d) Any money that is received by the office pursuant to this section shall be paid into the General Fund.

128775. (a) Any health facility affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within a greater time as the office, with the advice of the commission, may allow, and shall specifically describe the matters which are disputed by the petitioner.

(b) A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the office, an administrative law judge employed by the Office of Administrative Hearings, or a committee of the commission chosen by the chairperson for this purpose. If held before an employee of the office or a committee of the commission, the hearing shall be held in accordance with any procedures as the office, with the advice of the commission, shall prescribe. If held before an administrative law judge employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The employee, administrative law judge, or committee shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(c) Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil

Procedure. The decision of the office shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

(d) The employee of the office, the administrative law judge employed by the Office of Administrative Hearings, the Office of Administrative Hearings, or the committee of the commission, may issue subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Article 11 (commencing with Section 11450.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) This section shall become operative on July 1, 1997.

128780. Notwithstanding any other provision of law, the disclosure aspects of this chapter shall be deemed complete with respect to district hospitals, and no district hospital shall be required to report or disclose any additional financial or utilization data to any person or other entity except as is required by this chapter.

128782. Notwithstanding any other provision of law, upon the request of a small and rural hospital, as defined in Section 124840, the office shall do all of the following:

(a) If the hospital did not file financial reports with the office by electronic media as of January 1, 1993, the office shall, on a case-by-case basis, do one of the following:

(1) Exempt the small and rural hospital from any electronic filing requirements of the office regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(2) Provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer hardware and software necessary to comply with any electronic filing requirements of the office regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(b) The office shall provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer software and hardware necessary to comply with any electronic filing requirements of the office regarding reports specified in Sections 128735, 128736, and 128737.

(c) The office shall provide the hospital with assistance in meeting the requirements specified in paragraphs (1) and (2) of subdivision (c) of Section 128755 that the reports required by subdivision (g) of Section 128735 be filed by electronic media or by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an electronic file of



patient discharge abstract data records. The program or software shall incorporate validity checks and edit standards.

(d) The office shall provide the hospital with assistance in meeting the requirements specified in subdivision (d) of Section 128755 that the reports required by subdivision (a) of Section 128736 be filed by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an electronic file of emergency care data records. The program or software shall incorporate validity checks and edit standards.

(e) The office shall provide the hospital with assistance in meeting the requirements specified in subdivision (e) of Section 128755 that the reports required by subdivision (a) of Section 128737 be filed by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an electronic file of ambulatory surgery data records. The program or software shall incorporate validity checks and edit standards.

128785. On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission that relate to functions vested in the office and that are in effect on that date, shall remain in effect and shall be fully enforceable to the extent that they are consistent with this chapter, as determined by the office, unless and until readopted, amended, or repealed by the office following review and comment by the commission.

128790. Pursuant to Section 16304.9 of the Government Code, the Controller shall transfer to the office the unexpended balance of funds as of January 1, 1986, in the California Health Facilities Commission Fund, available for use in connection with the performance of the functions of the California Health Facilities Commission to which it has succeeded pursuant to this chapter.

128795. All officers and employees of the California Health Facilities Commission who, on December 31, 1985, are serving the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the office by this chapter shall be transferred to the office. The status, positions, and rights of persons shall not be affected by the transfer and shall be retained by them as officers and employees of the office, pursuant to the State Civil Service Act except as to positions exempted from civil service.

128800. The office shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, land, or other property, real or personal, held for the benefit or use of the California Health Facilities Commission for the performance of functions transferred to the office by this chapter.

128805. The office may enter into agreements and contracts with any person, department, agency, corporation, or legal entity as are necessary to carry out the functions vested in the office by this chapter or any other law.

128810. The office shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein. The commission shall advise and consult with the office in carrying out the administration of this chapter.